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	175160	A. BUILDING _____ B. WING _____	R 04/09/2012

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ROYAL TERRACE NURSING & REHABILITATION CENTER	201 E FLAMING RD OLATHE, KS 66061

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{F 000}	INITIAL COMMENTS The following citations represent the findings of a Non-compliance Resurvey and Complaint Investigations #KS 55262 and #KS 55069.	{F 000}		
{F 253} SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility identified a census of 112 residents. The sample included 9 residents. Based on observation, interview and record review, the facility failed to provide a sanitary environment by keeping resident care equipment clean and properly stored for 1 resident. (#1000) Findings included: - Resident #1000's Physician Order Sheet (POS) dated 3/2/12 listed diagnoses that included diabetes mellitus, constipation, joint pain in ankle and shoulder, acute respiratory failure, cardiomyopathy, abnormal posture, urinary tract infection, chronic respiratory failure, morbid obesity, atrial fibrillation, hypothyroidism, hypertension, depressive disorder, anxiety, shortness of breath, backache, deep vein thrombosis of lower extremity, congestive heart failure, acute kidney failure, obstructive sleep apnea, gastroesophageal reflux disease, tracheostomy, hematuria, anemia, chronic airway obstruction, urinary retention, pulmonary embolism/infarct, emphysema, psychosis,	{F 253}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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mononeuritis, diarrhea, neuropathy and insomnia.

The quarterly Minimum Data Set (MDS) 3.0 with an Assessment Reference Date of 3/23/12 recorded the resident had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The MDS further recorded the resident totally dependent on staff for bed mobility, transfers, dressing, toilet use, personal hygiene and required extensive staff assistance for eating, and did not walk or move in his/her wheelchair during the MDS assessment period. The MDS recorded the resident was frequently incontinent of bowel and bladder and not on a toileting program, was at risk for pressure ulcers, had other skin problems, had a pressure reducing device in the bed and chair and received dressings and ointments.

The urinary Care Area Assessment (CAA) dated 10/10/11 recorded the resident continued to require assist with toileting and hygiene, noted while in bed he/she used the urinal and would use the call light for assistance.

The Activities of Daily Living (ADL) care plan dated 10/15/11 directed when in bed the resident used the urinal for toileting with assistance of staff, he/she would use call the light when he/she needed to have a bowel movement, staff to provide hygiene care, the resident wore nothing at all in bed or sometimes wore a hospital gown, the resident had the right to refuse care offered, staff should assist with bathing at a minimum of 2 times weekly and as needed, staff should change linen as indicated and on shower days, assist with turning, or changing positions routinely as needed or requested for comfort and pressure reduction,

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offer toileting, and/or provide perineal care at these times if appropriate, keep frequently used items within reach at all times, the resident used a trapeze at the head of the bed to assist with bed mobility and repositioning, he/she used an electric wheelchair for mobility, at times staff to encourage him/her to slow chair down and watch for other residents, and 2 staff and the mechanical lift were required to transfer the resident in and out of bed.

The POS recorded the order dated 9/27/11, " Change humidified [oxygen] tubing every Sunday 10-6 [night shift]. "

During an interview on 3/28/12 at 10:03 A.M., the resident stated he/she did not get up to use the toilet, and used the urinal and the bedpan in his/her bed when he/she needed to urinate or have a bowel movement. Observation at that time revealed the resident lay in his/her bed with a tracheostomy in place. The resident's oxygen mask and oxygen tubing laid on the floor for his/her humidified oxygen, and the tubing was not labeled or dated. The resident's nebulizer machine (a device used to administer medication in the form of a mist inhaled into the lungs) was on a table and the Nebulizer tubing was not labeled or dated.

Observation in the resident's bathroom on 3/28/12 at 10:07 A.M. revealed 2 wash basins not bagged, on the floor behind the toilet. During an interview at that time, direct care staff I stated the resident did not take showers, staff gave him/her bed baths, and staff used the wash basins for bed baths. Direct care staff I further stated staff should bag the wash basins and not

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{F 253}	Continued From page 3 store them on the floor. During an interview on 3/28/12 at 10:16 A.M., licensed staff F stated the resident's wash basins should be changed every week, dated, placed in a bag and stored in the cabinet. Direct care staff I then placed the used wash basins in the garbage. During an interview on 3/28/12 at 11:16 A.M., licensed staff F stated staff should label and date the the oxygen tubing, and acknowledged the nebulizer tubing was not dated and stated staff should change the humidified oxygen mask and tubing on Sundays on the night shift. Licensed staff F removed the tubing and left the oxygen mask in place. During an interview and observation on 3/28/12 at 11:29 A.M., administrative nursing staff C stated he/she found the humidified oxygen tubing mask had a label and was dated 3/19/12, and acknowledged staff should have replaced them on 3/26/12 because they were replaced on Sundays on the night shift. Observation on 3/30/12 at 5:51 A.M. revealed the resident's bedpan sat on top of the resident's wheelchair and was not bagged, 2 urinals in the bathroom, 1 was bagged, the other one hung by the handle from the grab bar, not bagged, and both urinals had a brown-gray substance under the top lip of the urinals. During interview at that time, direct care staff J stated staff should bag the bedpan and place it in the bathroom, the resident should not have 2 urinals, and staff changed the urinals and bedpans on Sunday night shift and dated them when they changed them and threw away the old ones.	{F 253}		

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{F 253}	Continued From page 4 During an interview on 3/30/12 at 5:57 A.M. licensed staff E stated when the urinals were soiled, staff should rinse them with water, if the bed pan was soiled staff should disinfect it, staff should change the bedpans and urinals weekly and date the bedpans and urinals when staff changed them. Licensed staff E stated the bedpan should not have been on the wheelchair and the urinal should have been bagged. Licensed staff E used a gloved finger to remove some of the soil under the lips of the urinal tops and acknowledged staff should have removed and thrown away the urinals and replaced them with clean ones for the resident to use. During an interview on 4/3/12 at 4:17 P.M., administrative nursing staff B stated staff should replace the resident's wash basins, urinal and bedpan at least once a week (if visibly soiled, replace sooner), date them, bag them and place the basins in the cupboard and the urinals and bedpan in the bathroom cleaned and bagged after each use, and staff should replaced the resident's humidified oxygen mask and tubing weekly, labeled with the nurse's initials and dated. The facility lacked a policy for handling and storage of resident personal care equipment. The facility failed to maintain a sanitary environment for this resident.	{F 253}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	{F 280}		

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{F 280}	Continued From page 5 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility identified a census of 112 resident. The sample included 9 residents. Based on observation, interview and record review, the facility failed to include the resident to participate in planning care and treatment or changes in care and treatment for 1 resident (#1000), and failed to review and revise the plans of care for 2 residents. (#1000, #1005) Findings included: - Resident #1000's Physician Order Sheet (POS) dated 3/2/12 listed diagnoses that included diabetes mellitus, constipation, joint pain in ankle and shoulder, acute respiratory failure, cardiomyopathy, abnormal posture, urinary tract	{F 280}		

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infection, chronic respiratory failure, morbid obesity, atrial fibrillation, hypothyroidism, hypertension, depressive disorder, anxiety, shortness of breath, backache, deep vein thrombosis of lower extremity, congestive heart failure, acute kidney failure, obstructive sleep apnea, gastroesophageal reflux disease, tracheostomy, hematuria, anemia, chronic airway obstruction, urinary retention, pulmonary embolism/infarct, emphysema, psychosis, mononeuritis, diarrhea, neuropathy and insomnia.

The quarterly Minimum Data Set (MDS) 3.0 with an Assessment Reference Date of 3/23/12 recorded the resident had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The MDS further recorded the resident totally dependent on staff for bed mobility, transfers, dressing, toilet use, personal hygiene and required extensive staff assistance for eating, and did not walk or move in his/her wheelchair during the assessment period. The MDS recorded the resident was frequently incontinent of bowel and bladder and not on a toileting program, and was at risk for pressure ulcers, had other skin problems, had a pressure reducing device in the bed and chair and received dressings and ointments.

Review of the resident's care plan meeting conferences revealed a notice dated 12/13/11 for a care plan meeting. Review of the care plan meeting note lacked information the resident refused to attend the meeting and lacked information the resident attended the care plan meeting. The social services note lacked information the resident declined to attend the meeting.

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During an interview on 4/4/12 at 11:40 A.M., social service staff P stated he/she recorded the resident declined to come to the meeting if the resident did not show up for the meeting.

The resident's record lacked a notice for the resident's 3/20/12 care plan meeting, and the care plan meeting note lacked information the resident declined to attend. The social services note dated 3/20/12 recorded the resident declined to come [to the meeting].

During an interview on 4/4/12 at 11:48 A.M., administrative nursing staff S stated he/she sent the 12/13/11 notice to the resident by mail and did not talk to the resident or offer a meeting in the resident's room.

During an interview on 4/4/12 at 12:14 P.M., the resident stated staff never offered a meeting in his/her room and he/she would have accepted that offer "in a minute." The resident further stated if staff delivered a notice to him/her, he could not read it because he/she could not see well enough to read.

During an interview on 4/4/12 at 4:32 P.M., administrative nursing staff B stated the facility did not have a policy for care plan meetings, but used the Resident Assessment Instrument (RAI) manual as their policy.

The RAI user manual 3.0, chapter 4.7, pg. 4-11 identified the care plan process and one of the key steps and considerations to develop the care plan included, "Every effort should be made to include the input of the resident, family, or

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resident's representative in creating the individualized care plan. They should also be invited to participate in team discussions in an ongoing manner, and be encourage to share their perspectives on the delivery of care. This can be accomplished by having individual team members discuss preliminary care plan ideas with the resident, family, or resident representative in order to get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches."

The facility failed to include the resident in planning his/her care and treatment.

Review of the pressure ulcer Care Area Assessment (CAA) dated 10/10/11 recorded the resident required extensive assistance with bed mobility, was incontinent of bowel and bladder and received perineal care by staff after each incontinent episode, had a tracheostomy and received tracheostomy care per facility policy, had wound treatments for an open area under his/her abdominal fold and for an abdominal fistula every day and received weekly skin assessments.

The skin care plan updated on 3/20/12 directed staff to encourage the resident with adequate nutrition and supplements to prevent breakdown and promote healing, provide treatment to areas of skin breakdown , perform a skin assessment weekly and as needed, perform perineal care after each incontinent episode, use barrier cream after each incontinent episode, monitor laboratory values per orders, place a urinal at the resident's bedside, the resident would use the call light for assistance with bowel movements, observe for signs and symptoms of urinary tract infection,

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encourage the resident to drink fluids and keep fresh water at his/her bedside and within reach, assist with repositioning routinely and as needed for comfort, pressure relief and to prevent skin breakdown, encourage the resident to report any tender areas or cracked or torn skin, or reddened areas and the resident had a pressure relieving mattress/chair/cushion.

Observation of the wound treatments on 3/28/12 at 10:50 A.M. revealed the resident in bed and licensed staff F applied treatments and dressings on 3 wounds: 1 in the abdominal fold, 1 in the left thigh crease and 1 under the resident's right breast area.

During the findings meeting on 4/4/12 at approximately 5:00 P.M., administrative nursing staff B acknowledged the care plan was not specific and did not include information on the resident's 3 wounds.

The care plan lacked information on the location, treatment and measurable goals for the care of the resident's 3 wounds.

Review of the CAAs revealed the facility lacked an activities CAA for this resident.

The activities care plan updated on 3/20/11 directed, the resident enjoyed spending time outside in the fresh air sitting out visiting with peers, enjoyed independent routine in his/her room watching TV, listening to music, and visiting with roommate, and roommate's family members, enjoyed music groups, happy hour, monthly birthdays, enjoyed activities on an individual basis, enjoyed pet visits, sometimes refused to

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attend activities in and out of his/her room and his/her usual bedtime was 9:00 P.M. and liked to arise at 6:00 A.M. in the morning.

During an interview on 4/4/12 at 12:25 P.M., administrative nursing staff C stated the resident had not been up in his/her electric wheelchair in about 2 weeks, and had not gotten up from his/her bed in that time and had not had a roommate since 12/30/11.

During an interview on 4/4/12 at 2:23 P.M., activities staff N acknowledged the resident had not been out of bed for about 2 weeks, did not have a roommate since 12/30/11 and that the activities care plan did not reflect the resident's current interests and status.

During an interview on 4/4/12 at 4:32 P.M., administrative nursing staff B stated the facility did not have a policy for the revision of care plans, but used the Resident Assessment Instrument (RAI) manual as their policy.

The RAI user manual 3.0, chapter 4.7, pg. 4-8 and 4-9 directed, "The comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving."

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{F 280}	Continued From page 11 The facility failed to revise the resident's care plan to address his/her activity interests and physical abilities to participate in activities. The clinical record lacked evidence the facility revised the resident's care plan for activities and wound care and failed to include the resident in planning his/her care. - Resident #1005's diagnoses from the March 2012 Physician's Order Sheet (POS) included difficulty walking, symbolic dysfunction, nephritic syndrome, acute respiratory failure, lack of coordination, dysphagia, septicemia, and pneumonia. The Admission Minimum Data Set 3.0 Assessment (MDS) with the Assessment Reference Date (ARD) of 1-23-12 documented the resident ' s Brief Interview for Mental Status Score (BIMS) of 11, which indicated the resident had moderately impaired cognition, required extensive to total assistance with activities of daily living (ADLs), received dialysis, and had a history of falls. The 1-20-12 care plan identified the resident at risk for falls because the resident had end stage renal disease (ESRD), incontinence of bowel and bladder, weakness, impaired balance, a history of falls, impaired safety awareness, and short and long term memory loss. Interventions included a bed alarm, mattress on the floor and a high/low bed. The care plan lacked an intervention for a side rail. Observation on 3-30-12 at 5:20 A.M. revealed the	{F 280}		

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resident in a low bed pushed up against the wall on one side, had a mattress on the floor beside the bed and the side rail was up in the middle of the bed which prevented the resident from safely transferring to the mattress to sleep per his/her preference.

Observation on 3-30-12 at 12:16 P.M. revealed the resident in a low bed pushed up against the wall on one side, the mattress leaned against the closet on the other side of the room and the side rail up in the middle of the bed.

During an interview with the resident on 3-30-12 at 8:45 A.M. he/she stated he/she fell out of bed and broke his/her little finger on his/her left hand. He/she said the side rail kept him/her from falling and the mattress on the floor kept him/her from falling on the floor and getting hurt. He/she said he/she liked to sleep on the mattress but staff would not let him/her.

During staff interview on 4-3-12 at 4:17 P.M. Administrative Nursing staff B acknowledged the resident had a side rail raised in the middle of the resident ' s bed and stated he/she was not aware staff placed the side rail on the bed or why it was placed in the middle of the bed which prevented the resident from getting out of bed to sleep on the mattress per his/her preference.

Record review of the 3-22-12 dialysis communication form from the dialysis center recommended staff restrict the resident's fluid to1quart of fluid daily. Record review of the 3-27-12 dialysis communication form recommended that staff restrict the resident's fluids to 1-2 quarts daily.

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The 1-24-12 care plan identified the resident at risk for hydration and dehydration related to his/her ESRD, dialysis, low albumin, vitamin deficiency, anemia, gastroesophageal reflux disease (GERD) and use of diuretics. Interventions directed staff to monitor the resident for signs and symptoms of dehydration, offer appropriate fluids with meals, bedtime, and with medications. The care plan lacked interventions to identify the resident on a fluid restriction and how to monitor the amount of fluid the resident received.

Observation on 3-30-12 at 8:15 A.M. staff served the resident 2- 6 ounce (oz) glasses of water, an 8 oz cup of hot tea and a bowl of beef broth.

Observation on 3-30-12 at 8:35 A.M. direct care staff filled the resident's water pitcher with 550 cubic centimeters (cc) of water and placed it beside his/her wheelchair. During an interview with the resident at that time, he/she was unaware of any fluid restrictions and stated he/she could not drink certain juices because of his/her dialysis of the kidneys, but drank water when he/she was thirsty.

Observation on 3-30-12 at approximately 11:55 A.M. staff served the resident 2- 6 oz glasses of water and an 8-oz cup of hot tea.

During staff interview on 4-3-12 at 4:17 P.M. administrative nursing staff B stated staff did not monitor the resident's fluid restrictions and acknowledged the care plan lacked interventions for monitoring the fluid restrictions.

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{F 280}	Continued From page 14 During staff interview on 4-4-12 at 4:32 P.M. administrative nursing staff B stated the facility did not have a policy for the revision of care plans, but used the Resident Assessment Instrument (RAI) manual as their policy. The RAI user manual 3.0, chapter 4.7, pg4-8 and 4-9 directed, "The comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving." The facility failed to review and revise the resident's care plan to include the use of a side rail which prevented the resident from getting out of bed safely and failed to provide interventions for monitoring the resident's fluid restrictions.	{F 280}		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility identified a census of 112 residents. The sample included 9 residents. Based on observation, interview and record review, the	F 281		

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F 281	Continued From page 15 facility failed to follow and execute the dentist's order for treatment for 1 resident. (#1002) Findings included: - Resident # 1002's diagnoses from the Physician's Order Sheet (POS) dated January 2012 included osteoarthritis, morbid obesity, intellect disability, deep vein thrombosis, bipolar disorder, convulsions, hypothyroid, urinary tract infection, and stridor. The quarterly Minimum Data Set 3.0 Assessment (MDS) with the Assessment Reference Date (ARD) of 11-14-11 documented the resident with short and long term memory loss, and severely impaired decision making. The MDS further documented the resident required extensive assistance with bed mobility, total assistance with transfers, toileting, and personal hygiene and was incontinent of bowel and bladder. The ADL care plan 2/16/11 directed, the resident required extensive to total assistance for cares, staff provide and assist with oral care 2 times per day and as needed,the resident resisted care at times with activities of Daily Living (ADLs), transfers, and toileting, staff to reapproach when he/she refused care and 2 staff should assist the resident to transfer with the Hoyer lift. Observation on 3/30/12 at 11:37 A.M. revealed the resident lay in his/her bed. The dental evaluation dated 3/8/12 recorded the resident had inflammation from gingivitis.	F 281		

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F 281	Continued From page 16 The dentist's order dated 3/8/12 directed, Hydrogen peroxide 3 percent (%) solution, dilute 1 part to 1 part water, 10 cubic centimeters (cc). Swab mouth 4 times per day for 28 days with damp not wet swab. The POS dated March 2012 recorded the same order dated 3/8/12. Review of the March 2012 Treatment Administration Record (TAR) and the Medication Administration Record (MAR) lacked evidence of the order. During an interview on 4/4/12 at 11:11 A.M., licensed staff F stated he/she did not do the hydrogen peroxide treatment on the resident's mouth in March, but attempted to that day and the resident refused. Licensed staff F stated he/she attempted to use the mouth sponges provided by the facility and did not use hydrogen peroxide as ordered. During an interview on 4/4/12 at 11:21 A.M., administrative nursing staff C stated the dentist's order was not on the TAR or the MAR for March. According to the Kansas Nurse Practice Act Statutes & Administrative Regulations dated January 2012, Section 65-1113 (d)(1), The practice of professional nursing...means the process in which substantial specialized knowledge derived from the biological, physical, and behavioral sciences is applied to... the execution of the medical regimen as prescribed by a person licensed to practice medicine and surgery or a person licensed to practice dentistry.	F 281		

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F 281	Continued From page 17 The facility failed to follow and execute the dentist's order for treatment for this resident with gingivitis.	F 281		
{F 309} SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility identified a census of 112 residents. The sample included 9 residents. Based on observation, interview, and record review the facility failed to provide adequate pain relief and monitor fluid restriction for 1 sampled resident (#1005) and failed to provide education to prevent the development of a wound for 1 sampled resident (#1007) - Resident #1005's diagnoses from the March 2012 Physician's Order Sheet (POS) included difficulty walking, symbolic dysfunction, nephritic syndrome, acute respiratory failure, lack of coordination, dysphagia, septicemia, and pneumonia. The Admission Minimum Data Set 3.0 Assessment (MDS) with the Assessment Reference Date (ARD) of 1-23-12 documented the resident's Brief Interview for Mental Status	{F 309}		

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Score (BIMS) of 11, which indicated the resident had moderately impaired cognition, required extensive to total assistance with activities of daily living (ADLs) and did not receive scheduled or as needed (PRN) pain medication.

The 1-20-12 care plan identified the resident at risk for falls because the resident had end stage renal disease (ESRD), incontinence of bowel and bladder, weakness, impaired balance, a history of falls, impaired safety awareness, and short and long term memory loss. The care plan lacked any interventions for pain management.

The February 2012 Medication Administration Record (MAR) documented an order for generic Tylenol 325 milligrams (mg) 2 tablets every 4 hours as needed (PRN) for pain.

During record review on 1-20-12 (with no time written) the nurses' note (NN) documented the resident required assistance of 2 staff for ADLs, was weak on his/her left side and was able to make his/her needs known.

On 2-12-12 (with no time written) the NN documented the resident with a non-injury fall as staff noted the resident laid on the floor on his/her right side.

On 2-15-12 at 1:15 A.M. the NN documented the resident yelled and complained of pain in his/her left wrist and staff offered him/her Tylenol (an analgesic medication) and the resident refused stating, "I want stronger medicine." The record lacked evidence staff notified the physician or offered any non-pharmacological interventions for the resident's complaint of pain.

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{F 309}	Continued From page 19 On 2-16-12 at 11:30 P.M. the NN documented the resident complained of pain in his/her left wrist and refused to take Tylenol. Staff repositioned the resident. Record review of the skilled nurse's note for pain documentation on all 3 shifts documented the resident was comfortable. The record lacked evidence staff notified the physician of the in-effectiveness of the Tylenol or offered any non-pharmacological interventions for the resident's complaint of pain. On 2-17-12 at 1:30 P.M. the NN documented the resident complained of wrist pain and the physician ordered an X-ray of the left wrist. At 4:30 P.M. the resident complained of pain in his/her left wrist and refused the Tylenol because it did not work for him/her and it upset his/her stomach. At 5:30 P.M. the NN documented staff spoke to the Advanced Registered Nurse Practitioner (ARNP) and he/she would see the resident the next day (2-18-12). The record lacked evidence staff notified the practitioner of the resident ' s complaint of pain and in-effectiveness of the Tylenol or offered any non-pharmacological interventions for the resident's complaint of pain. Record review of the 2-17-12 X-ray of the wrist with 3 views documented a mildly angulated distal fifth metacarpal (little finger) fracture. On 2-18-12 at 12:00 noon the NN documented the x-ray of the resident's hand showed a fracture and he/she saw the ARNP and received an order for Lortab (also prescribed as Narco which is a narcotic pain medication) three days after the resident complained of pain.	{F 309}		

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{F 309}	Continued From page 20 Record review of the POS on 2-18-12 documented an order for Narco (also prescribed as Lortab, 5/325 mg 1 or 2 tablets by mouth every 4-6 hours PRN for pain for 2 weeks. Record review of the 2-18-12 Physician's Progress Note documented the resident with left hand pain since recent fall and was worse the last few days. The resident pointed to the 5th metacarpal site with the most pain today. He/she ordered staff to immobilize the hand and referred the resident to and orthopedic doctor for evaluation and treatment of the fracture. Observation on 3-20-12 at 5:40 A.M. revealed the resident with his/her call light on. Direct care staff J entered the resident ' s room and the resident requested direct care staff J to massage his/her left wrist and stated it hurt. At that time during an interview with the resident he/she stated his/her hand hurt because he/she fell out of bed and broke his/her finger. When asked when it happened he/she said several weeks ago he/she fell out of bed onto the floor and broke his/her finger. During staff interview on 3-30-12 at 5:48 A.M. direct care staff J stated the resident used his/her call light and was able to state his/her needs which included pain. On 3-30-12 at 8:35 A.M. during an interview with the resident he/she stated he/she fell off the bed and broke his/her finger and it hurt a lot and now was better after staff wrapped it. He/she stated it still hurt at times but not as bad as before and the pain medication did not help at first but after they	{F 309}		

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{F 309}	Continued From page 21 wrapped it the medication helped. During staff interview on 3-30-12 at 5:34 A.M. licensed staff H stated the staff monitored residents for pain every shift and this resident was able to state his/her needs and tell the staff when he/she had pain. He/she said if a resident complained that the pain medication was in-effective, he/she should call the physician. During staff interview on 4-3-12 at 1:53 P.M. direct care staff I stated the resident used the call light or yelled out for help if he/she needed something and was able to state his/her needs. During staff interview on 4-3-12 at 3:15 P.M. licensed staff G stated the resident used his/her call light for his/her needs. During staff interview on 4-3-12 at 4:17 P.M. Administrative Nursing staff B acknowledged the resident was able to state his/her needs and staff should have notified the physician when he/she complained the pain medication was ineffective. On 4-4-12 at 10:50 A.M. during staff interview administrative nursing staff C stated that if the resident had pain medication in place and complained it was not effective, staff should call the physician. He/she reviewed the record and acknowledged staff failed to notify the physician for 2 days after the resident complained the Tylenol was in-effective for his/her pain. The 8/10 facility provided Pain Management policy documented that comfort promotion and pain relief interventions included non-pharmacological interventions as well as	{F 309}		

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PRN and scheduled pain medications, identify the current discomfort and pain level, potential for pain, and evaluate the effectiveness of interventions to promote comfort and minimize pain.

The facility failed to notify the physician for 3 days following this dependent resident's complaint that the over the counter pain medication Tylenol was in-effective for pain relief following his/her fall and subsequent fracture of his/her left finger.

- Resident #1005's diagnoses from the March 2012 Physician's Order Sheet (POS) included difficulty walking, symbolic dysfunction, nephritic syndrome, acute respiratory failure, lack of coordination, dysphagia, septicemia, and pneumonia.

The Admission Minimum Data Set 3.0 Assessment (MDS) with the Assessment Reference Date (ARD) of 1-23-12 documented the resident ' s Brief Interview for Mental Status Score (BIMS) of 11, which indicated the resident had moderately impaired cognition, required extensive to total assistance with activities of daily living (ADLs) and received dialysis services.

The 1-25-12 Dehydration/Fluid Maintenance Care Area Assessment summary (CAA) documented the resident was at risk for dehydration related to his/her dialysis and daily use of Lasix (a medication to help prevent retention of fluid). The CAA documented that staff kept fluids at the resident's bedside, weighed the resident monthly and as needed and monitored the resident for increased edema in his/her extremities or increased weight.

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The 1-24-12 care plan identified the resident at risk for hydration related to his/her end stage renal disease (ESRD), dialysis, and use of diuretics. Interventions directed staff to monitor the resident for signs of dehydration, check the skin for turgor, monitor for confusion, decreased output, and check the oral mucosa daily. The care plan directed staff to offer the resident the appropriate fluids with meals, bedtime, and with medications. The care plan lacked interventions for monitoring the resident's fluid restrictions.

Record review of the 3-22-12 dialysis communication form directed staff to restrict the resident to 1 quart of fluid daily.

Record review of the 3-27-12 dialysis communication form directed staff to restrict the resident to 1-2 quarts of fluid daily.

Observation on 3-30-12 at 8:15 A.M. staff served the resident breakfast and provided 2- 6 ounce (oz) glasses of water and an 8 oz cup of hot tea. At approximately 8:40 A.M. staff propelled the resident to his/her room and filled the resident's water pitcher with 550 milliliters (ml) of water.

Observation on 3-30-12 at approximately 11:50 A.M. staff served the resident his/her meal and provided 2-6 oz glasses of water and an 8 oz cup of hot tea.

Observation on 4-3-12 at 1:41 P.M. revealed the water pitcher in the resident's room with 450 ml of water in it.

On 3-30-12 at 8:35 A.M. during an interview with

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the resident, he/she was unaware of any fluid restrictions and stated he/she could not drink certain juices because of his/her dialysis of the kidneys, but drank water when he/she was thirsty.

On 4-3-12 at 1:53 P.M. during staff interview direct care staff I was unaware the resident had a fluid restriction and stated he/she did not monitor any fluid intake on the resident and that the restorative aide kept track of fluids residents received.

On 4-3-12 at 2:20 P.M. direct care staff L stated he/she did not monitor the resident's fluid intake and said the certified nursing assistants (CNA) did.

On 4-3-12 at 3:15 P.M. during staff interview licensed nurse G was not aware the resident had a fluid restriction.

On 4-3-12 at 4:17 P.M. administrative nurse B stated the staff did not monitor the resident ' s fluid intake and found the order for fluid restriction the end of last week. He/she stated he/she talked to dietary about it. He/she acknowledged staff provided the resident with a water pitcher today and were not aware of monitoring the resident's fluid intake.

The 8/10 facility provided Intake and Output Monitoring policy documented to record all fluids consumed during a 24 hour period for identified residents and review and revise the care plan as indicated.
The facility failed to identify this dependent resident required fluid restriction and failed to monitor his/her intake as directed by dialysis.

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- Resident #1007's diagnoses from the March 2012 Physician's Order Sheet (POS) included morbid obesity, chronic airway obstruction, chronic bronchitis with exacerbation, congestive heart failure, chronic pain, diabetes mellitus, abnormal posture, candidiasis, and osteoarthrosis.

The quarterly Minimum Data Set 3.0 Assessment (MDS) with the Assessment Reference Date (ARD) of 3-7-12 documented the resident's Brief Interview for Mental Status Score (BIMS) of 15 which indicated the resident was independent with decision making, required total assistance for activities of daily living (ADLs) and had problems with his/her skin.

The 9-21-11 ADL Care Area Assessment summary (CAA) documented the resident had morbid obesity, a body rash, required assistance with ADLs and transfers, and spent most of his/her time in bed.

The 12-8-11 Braden (a type of assessment used to determine the risk for developing skin breakdown) assessment documented the resident with a score of 13 which indicated the resident was at moderate risk for the development of a skin breakdown.

The 3-20-12 care plan identified the resident at risk for skin integrity related to his/her morbid obesity, neurogenic bladder with an indwelling foley catheter, urinary tract infection, and the other diagnoses listed above. The care plan documented the resident required total assistance with ADLs and directed staff to apply

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creams to the body rash, report any reddened, cracked, or torn skin, provide the resident with a pressure relieving cushion for his/her wheelchair and a therapeutic pressure relieving bariatric mattress. The care plan also directed staff to reposition the resident routinely for comfort and prevention of skin breakdown, and offer repositioning because the resident did not like to reposition him/her. The care plan documented the resident had chronic pain and required scheduled pain medications and directed staff to reposition the resident for comfort and he/she refused at times.

Observation on 4-3-12 at 9:25 A.M. revealed direct care staff O and M provided perineal care to the resident and repositioned the resident onto his/her right side to clean the buttocks. When staff turned the resident his/her buttocks had an appearance of being pressed together and had a purplish defined line on each buttock when staff separated the buttocks to cleanse the resident. At that time observation revealed a superficial open area approximately 2 centimeters (cm) circumference with a red, bloody wound bed.

On 4-3-12 at 10:45 A.M. during staff interview licensed staff R stated he/she notified the wound nurse regarding the resident ' s open area on his/her buttock.

On 4-3-12 at 3:50 P.M. administrative nurse D acknowledged staff informed him/her of the open area on the resident ' s right inner buttock and it measured 1.5 cm length x 1.5 cm width with no depth and did not feel it was pressure but due to moisture in the folds of the skin because the left and right buttocks are pressed together.

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During staff interview on 4-4-12 at 11:20 A.M. administrative nurse D stated staff placed a wedge under one side of the resident to relieve pressure to the buttock area.

During observation on 4-4-12 at 1:49 P.M. the resident lay in his/her bed with his/her head elevated approximately 30 degrees and the wedge pillow was on the floor by the wall. During an interview at that time the resident stated he/she was not aware of the wedge pillow for positioning and when asked, stated he/she liked to lay on his/her back while in bed, and did not recall staff informing or educating him/her of any risk of skin breakdown from not repositioning.

On 4-4-12 at 11:20 A.M. administrative nurse D reviewed the resident's record and stated he/she did not find evidence staff educated the resident of the risk of not repositioning him/herself while in bed.

During staff interview on 4-4-12 at 3:00 P.M. administrative staff A stated the director of nursing should educated the resident on the risk of not repositioning and would document it in the resident's record and provide follow up with the resident. He/she acknowledged the record lacked evidence staff educated the resident about not repositioning.

The facility did not have a policy regarding educating the resident about the risk of not repositioning.

The facility failed to provide education about the risk of not repositioning his/herself in bed to

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{F 309}	Continued From page 28 prevent the development of wounds and this dependent resident developed a wound on his/her right buttock.	{F 309}		
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 112 residents. The sample included 9 residents. Based on observation, interview, and record review the facility failed to provide adequate perineal care and prevent backflow of urine for 1 of 3 sampled residents (#1007), and failed to provide complete incontinence care for 1 sampled resident. (#1002) Findings included: - Resident #1007's diagnoses from the March 2012 Physician's Order Sheet (POS) included morbid obesity, chronic airway obstruction, chronic bronchitis with exacerbation, congestive heart failure, chronic pain, diabetes mellitus, abnormal posture, candidiasis, and osteoarthrosis.	{F 315}		

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The quarterly Minimum Data Set 3.0 Assessment (MDS) with the Assessment Reference Date (ARD) of 3-7-12 documented the resident's Brief Interview for Mental Status Score (BIMS) of 15 which indicated the resident was independent with decision making, required total assistance for activities of daily living (ADLs), was incontinent of bowel and had an indwelling foley catheter.

The 9-21-11 Urinary CAA documented the resident had a chronic history of urinary tract infections (UTI), had an indwelling foley catheter, and staff provided catheter care every shift.

The 9-21-11 ADL Care Area Assessment summary (CAA) documented the resident had morbid obesity, required assistance with ADLs and transfers, and spent most of his/her time in bed.

The 3-20-12 care plan identified the resident with an indwelling foley catheter related to a neurogenic bladder and interventions directed staff to, among other things, keep the drainage bag below the level of the bladder, observe for signs and symptoms of a UTI, and provide catheter care every shift.

Observation on 3-30-12 at 9:34 A.M. direct care staff O and direct care staff M transferred the resident from the bed into his/her wheelchair via the Hoyer (a mechanical device used to lift residents) lift. Direct care staff O handed the foley catheter bag to the resident and he/she placed the catheter bag on his/her stomach, which was higher than the level of the bladder, and held onto it during the transfer and while staff

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O and M situated the resident into the wheelchair, then staff M placed the bag under the wheelchair into the privacy bag.

During record review the resident's urinary analysis (UA) on 3-29-12 documented the following abnormal results:
The clarity of the urine was hazy and normal appearance should be clear. The urine had 2 plus (+) leukocytes (white blood cells in the urine that may indicate a UTI) and normal should have been without any leukocytes, 1+ protein (which may indicate kidney disease) and normal should have been negative, had 0-3 high power field (HPF) white and red blood cells and normal should have been negative, had a moderate amount of bacteria cells and normal should have been negative. The culture and sensitivity (C&S) documented the resident with P. Mirabilis (a small gram-negative bacillus) and the colony count was over 100,000.

On 4-2-12 at 1:00 P.M. the nurse's note documented staff notified the physician and he/she ordered Pyridium (a urinary analgesic medication used for symptom relief associated with a UTI) 200 milligrams (mg) by mouth twice daily for 3 days for a UTI.

Observation on 4-3-12 at 9:25 A.M. revealed the resident on his/her back in the bed and direct care staff O provided perineal care to the resident. Direct care staff O cleaned the resident ' s groin area and outside his/her labia, but failed to separate the labia and cleanse the catheter around the urethra area. During the observation the foley catheter bag lay on the bed, which was higher than the level of the bladder and had

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cloudy amber urine in the tubing which flowed back towards the resident. The resident complained of pain and stated several times that it burned very bad and felt he/she had spasms of his/her bladder because the pain was bad. He/she grimaced and appeared anxious during cares.

During staff interview on 4-3-12 at 10:25 A.M. direct care staff O stated he/she would report any abnormal color of the urine, blood in the urine, resident's complaint of pain with a catheter or while urinating, or odors of the urine to the charge nurse.

During staff interview on 4-3-21 at 2:40 P.M. administrative licensed nurse B stated that staff should keep the foley catheter bag at or below the level of the bladder at all times and while providing foley catheter care, should separate the labia cleanse the urethral area and around the foley catheter tubing. He/she acknowledged staff failed to maintain the foley catheter bag at or below the level of the bladder and failed separate the labia to cleanse the urethral opening around the foley catheter tubing.

Observation on 4-4-12 at 9:50 A.M. revealed the resident's foley catheter bag in a privacy bag and lay beside the resident on the bed and the tubing had cloudy yellow urine in it. The bag was not at or below the level of the resident's bladder.

During staff interview on 4-4-12 at 9:53 A.M. licensed staff R acknowledged the foley catheter bad lay next to the resident on the bed.

During staff interview on 4-3-12 at 3:00 P.M.

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licensed nurse R stated the resident has had an indwelling foley catheter several times, acknowledged his/her complaint of pain and UTI and stated the resident has asked staff to push the tubing in further or out further at times because of pain. He/she acknowledged that staff should have kept the catheter drainage bag at or below the level of the bladder.

The facility provided 6/08 Catheter Care of an Indwelling foley catheter policy and procedure documented to cleanse the entire perineal area with soap and water or perineal wash and separate the labia and cleanse from the center to thigh front to back and gently cleanse the urethral/catheter juncture. The policy also directed staff to maintain the catheter drainage bad below the level of the bladder to facilitate flow of urine.

The facility failed to provide complete and appropriate catheter care and failed to maintain the catheter at or below the resident's bladder.

- Resident #1002's diagnoses from the Physician's Order Sheet (POS) dated January 2012 included osteoarthritis, morbid obesity, intellect disability, deep vein thrombosis, bipolar disorder, convulsions, hypothyroid, urinary tract infection, and stridor.

The quarterly Minimum Data Set 3.0 Assessment (MDS) with the Assessment Reference Date (ARD) of 11-14-11 documented the resident with short and long term memory loss, and severely impaired decision making. The MDS further documented the resident required extensive

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assistance with bed mobility, total assistance with transfers, toileting, and personal hygiene and was incontinent of bowel and bladder.

The incontinence care plan dated 2/16/11 directed, staff to monitor skin with all incontinent care for signs or symptoms of excoriation or rash, the resident used incontinent briefs, staff to toilet the resident upon rising, before and after meals, as needed and during waking hours check the resident and change the brief, the resident was unable to advise staff of need to be toileted, the resident required extensive to total staff assistance with managing incontinent care, the resident wore XXL size briefs daily for incontinence, staff perform weekly skin assessment, staff to apply creams or powders per orders, the resident had a pressure relieving mattress and wheelchair cushion, the resident refused to lay down after meals at times and preferred to sit up in his/her wheelchair, the resident was able to reposition himself/herself in bed at times, the resident resisted toileting and incontinence care and changing of soiled clothes at times, and staff should reapproach later or with a different staff member when the resident resisted care, and staff to reposition the resident in bed and wheelchair routinely and as needed. Observation on 4/3/12 at 2:07 P.M. revealed direct care staff U and direct care staff I transferred the resident to his/her bed for incontinent care, removed the saturated brief and cleaned the resident's right and left gluteus but failed to provide complete frontal care.

During an interview on 4/4/12 at 4:12 P.M., direct care staff V stated staff should clean the entire area where the brief touched the skin.

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{F 315}	Continued From page 34 During an interview on 4/3/12 at 4:17 P.M., administrative nursing staff B stated direct care staff should observe the resident during care and report a new open report to the nurse, and staff should clean the entire area of the resident's skin, including where the brief was. The facility failed to provide a policy directing staff on perineal care. The facility failed to provide complete incontinence care.	{F 315}		
{F 323} SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 112 residents. The sample included 9 residents. Based on observation, interview, and record review the facility failed to implement and monitor interventions to prevent injury of a fracture for 1 of 3 sampled residents for falls. (#1005) Findings included: - Resident #1005's diagnoses from the March 2012 Physician's Order Sheet (POS) included	{F 323}		

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difficulty walking, symbolic dysfunction, nephritic syndrome, acute respiratory failure, lack of coordination, dysphagia, septicemia, and pneumonia.

The Admission Minimum Data Set 3.0 Assessment (MDS) with the Assessment Reference Date (ARD) of 1-23-12 documented the resident's Brief Interview for Mental Status Score (BIMS) of 11, which indicated the resident had moderately impaired cognition, required total assistance with bed mobility and was incontinent of bowel and bladder.

The 1-25-12 Falls Care Area Assessment summary (CAA) documented the resident with short and long term memory impairment and had unrealistic expectations with his/her level of function for activities of daily living (ADLs). The CAA also documented the resident had a bed and chair alarm on at all times, mattress on the floor at the bedside, and side rails for safety and repositioning.

The 1-20-12 care plan identified the resident at risk for falls because the resident had end stage renal disease (ESRD), incontinence of bowel and bladder, weakness, impaired balance, a history of falls, impaired safety awareness, and short and long term memory loss. The interventions included the falling star program (a program to help prevent falls and injury while promoting and supporting resident mobility), keep frequently used items and call light in reach, and provide extensive assistance with transfers. On 1-25-12 the care plan documented the resident with a non-injury fall and implemented a bed alarm. On 1-26-12 the care plan documented the resident

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with a non-injury fall and implemented a mattress on the floor beside the bed for cultural purposes because the resident preferred it. On 2-5-12 the care plan implemented a high/low bed for the resident. On 2-12-12 the care plan documented a non-injury fall and implemented a physical therapy and occupational therapy evaluation and placed the bed against the wall.

During record review on 1-20-12 (with no time written) the nurses' note (NN) documented the resident required assistance of 2 staff for ADLs, was weak on his/her left side and was able to make his/her needs known.

On 1-22-12 (with no time written) the NN documented the resident required a Hoyer lift (a lift device used to transfer residents) for transfers and staff propelled the resident in his/her wheelchair. At 8:00 P.M. the NN documented the resident used his/her call light for needs.

On 1-24-12 at 3:00 P.M. the NN recorded staff found the resident on the floor and he/she declined any pain. The resident told staff he/she wanted a drink of water and staff educated the resident on the use of the call light. Record review of the fall investigation report recommended a bed and chair alarm, review of the incident by the fall team and to continue with therapy.

On 1-25-12 at 4:00 A.M. the NN documented staff found the resident with his/her head on the mattress that was on the floor and his/her body off the mattress and on the floor. The note further documented the resident wanted to sleep on the mattress on the floor. Record review of

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the fall investigation report documented the resident wanted to sleep on the floor and staff placed a mattress on the floor beside the resident's bed.

On 1-26-12 (with no time written) the NN documented staff found the resident on the floor because he/she wanted to lie on the floor. The NN also documented the resident preferred to sleep on a regular mattress on the floor due to his/her culture. Staff placed a mattress on the floor next to his/her bed. Record review of the 1-25-12 fall investigation revealed staff placed a mattress on the floor beside the resident's bed because the resident wanted to sleep on the floor per his/her culture. Record review of the 1-26-12 investigation documented staff found the resident on the floor and the resident wanted to lay on the floor.

On 2-12-12 (with no time written) the NN documented the resident with a non-injury fall as staff noted the resident laid on floor on his/her right side. The record lacked evidence staff placed an alarm on the resident or had the mattress beside the bed. Review of the fall investigation report documented the resident continued to receive Physical therapy and Occupational therapy.

On 2-15-12 at 1:15 A.M. the NN documented the resident yelled and complained of pain in his/her left wrist and staff offered him/her Tylenol (an analgesic medication) and the resident refused stating, "I want stronger medicine." The record lacked evidence staff placed an alarm on the resident or had the mattress beside the bed.

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On 2-16-12 at 11:30 P.M. the NN documented the resident complained of pain in his/her left wrist and refused to take Tylenol. Staff repositioned the resident.

On 2-17-12 at 1:30 P.M. the NN documented the resident complained of wrist pain and the physician ordered an X-ray of the left wrist. At 4:30 P.M. the resident complained of pain in his/her left wrist and refused the Tylenol because it did not work for him/her and it upset his/her stomach. At 5:30 P.M. the NN documented staff spoke to the Advanced Registered Nurse Practitioner (ARNP) and he/she would see the resident the next day. (2-18-12)

On 2-18-12 at 12:00 noon the NN documented the resident saw the ARNP and received an order for Lortab pain medication.

Record review of the POS documented an order for Narco 5/325 milligrams (mg) 1 or 2 tablets by mouth every 4-6 hours as needed for pain for 2 weeks.

Record review of the 2-17-12 X-ray of the wrist with 3 views documented a mildly angulated distal fifth metacarpal (little finger) fracture.

Record review of the 2-18-12 Physician's Progress Note documented the resident with left hand pain since recent fall and was worse the last few days. The resident pointed to the 5th metacarpal site with the most pain today. He/she ordered staff to immobilize the hand and referred the resident to an orthopedic doctor for evaluation and treatment of the fracture.

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Observation on 3-20-12 at 5:40 A.M. revealed the resident with his/her call light on. Direct care staff J entered the resident's room and the resident requested direct care staff J massage his/her left wrist stating it hurt. Further observation revealed the resident in a low bed in which one side was up against the wall. A mattress was on the floor beside the bed and the side rail which was in the middle of the bed was in the up position. At that time during an interview with the resident he/she stated his/her hand hurt because he/she fell out of bed and broke his/her finger. When asked when it happened he/she said several weeks ago he/she fell out of bed onto the floor and broke his/her finger.

Observation on 3-30-12 at 12:16 P.M. revealed the resident in bed with his/her eyes closed, the bed was up against the wall and in the low position and the side rail was up in the middle of the bed. The mattress was up against the closet on the opposite side of the room and the alarm was in the wheelchair and not on the resident.

During staff interview on 3-30-12 at 5:48 A.M. direct care staff J stated the resident used his/her call light and was able to state his/her needs.

During an interview with the resident on 3-30-12 at 8:35 A.M. the resident stated his/her left hand hurt because he/she fell off the bed and broke his/her finger. He/she also stated they had a wrap on it and it was better now.

During staff interview on 4-3-12 at 1:53 P.M. direct care staff I stated he/she transferred the alarm from the chair to the bed and resident did not have two alarms. He/she said the resident

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{F 323}	Continued From page 40	{F 323}		

did not attempt to get out of his/her bed on his/her own and used the call light or yelled out for help if he/she needed something.

During staff interview on 4-3-12 at 3:15 P.M. licensed staff G was unaware of any of the resident's falls and stated if he/she was at risk for falls then staff would put an alarm on the bed and a mattress on the floor. Licensed staff G also stated the resident used his/her call light, was able to state his/her needs, and staff kept the call light in reach for him/her.

During staff interview on 4-3-12 at 4:17 P.M. Administrative Nursing staff B acknowledged the resident did not have the alarm on while the resident was in his/her bed or when in his/her wheelchair and stated staff should put it on the resident and place the mattress on the floor beside the bed. He/she stated the mattress was put on the floor beside the resident's bed for cultural reasons because the resident slept on a mattress on the floor in his/her home. When asked why the side rail was up on the bed which prevented the resident from getting on the mattress, he/she did not know why the side rail was up. Administrative nursing staff B also acknowledged staff did not place the bed in a low position, according to the care plan, until a week after the second fall.

The 8/10 facility provided Fall Risk Reduction and Management documented the interdisciplinary team (IDT) worked with the resident and or family to identify and implement appropriate interventions to reduce the risk of falls or injury while maximizing dignity and independence. Post fall management included appropriate resident

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{F 323}	Continued From page 41 care, evaluation and revision of existing interventions and protocol factors to determine areas of improvement. The facility failed to provide interventions as planned for this dependent resident with a history of falls that resulted in a fracture.	{F 323}		
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	{F 329}		

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{F 329}	Continued From page 42 The facility identified a census of 112 residents. The sample included 9 residents. Based on observation, interview, and record review the facility failed to hold 1sampled resident ' s blood pressure medication as ordered by the physician (#1005), and failed to monitor the pulse before administering digoxin (a medication used to treat heart failure and/or atrial fibrillation) for 1 sampled resident. (#1000) Findings included - Resident #1005's diagnoses from the March 2012 Physician's Order Sheet (POS) included difficulty walking, symbolic dysfunction, nephritic syndrome, acute respiratory failure, lack of coordination, dysphagia, septicemia, and pneumonia. The Admission Minimum Data Set 3.0 Assessment (MDS) with the Assessment Reference Date (ARD) of 1-23-12 documented the resident's Brief Interview for Mental Status Score (BIMS) of 11, which indicated the resident had moderately impaired cognition, and required extensive to total assistance with activities of daily living (ADLs). Record review of the March 2012 POS documented an order for carvedilol (an antihypertensive blood pressure (BP) medication) 3.125 milligrams (mg) by mouth (po) twice daily (BID) and hold the medication if the residents systolic blood pressure fell below 130, and amlodipine besylate (an antihypertensive blood pressure medication) 5 mg at bedtime and hold the medication if the resident's systolic blood pressure fell below 120.	{F 329}		

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{F 329}	Continued From page 43	{F 329}		

Record review of the March 2012 Medication Administration Record (MAR) documented the following BP's for carvedilol:

On 3-22-12 at 8:00 A.M. staff recorded the resident's systolic BP of 124 and at 6:00 P.M. 122. Staff recorded the resident received carvedilol 3.125 mg.

On 3-23-12 at 6:00 P.M. staff recorded the resident's systolic BP of 128 and staff recorded the resident received carvedilol 3.125 mg.

On 3-24-12 at 6:00 P.M. staff recorded the resident's systolic BP of 104 and staff recorded the resident received carvedilol 3.125 mg.

On 3-26-12 at 8:00 A.M. staff recorded the resident's systolic BP of 116 and staff recorded the resident received carvedilol 3.125 mg. At 6:00 P.M. staff recorded the resident's BP of 128 and staff recorded the resident received carvedilol.

On 3-27, 28, & 29 -12 at 6:00 P.M. the MAR was blank and lacked a BP recording or documentation why. On 3-28-12 the MAR documented the resident was in the hospital. The clinical record lacked evidence the resident was in the hospital at this time or why staff did not check the resident's BP or give the medication.

On 3-31-12 at 6:00 P.M. staff recorded the systolic BP of 128 and gave the resident carvedilol 3.125 mg.

The March MAR documented the following for amlodipine besylate 5mg po at bedtime (HS):

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{F 329}	Continued From page 44 On 3-15-12 at HS staff recorded the resident's systolic BP of 101 and recorded the resident received amlodipine besylate 5 mg. On 3-20-12 at HS staff recorded the resident's systolic BP of 118 and recorded the resident received amlodipine besylate 5 mg. Observation on 4-3-12 at 3:15 P.M. revealed the resident sat in his/her wheelchair in his/her room and the nurse was outside the resident's room with the medication cart. During staff interview on 4-3-12 at 3:15 P.M. licensed nurse G stated the certified medication assistants (CMA) passed medications. He/she confirmed the resident's orders for BP medication and stated if the BP fell below the parameters ordered by the physician then staff should hold the medication and inform the nurse. He/she was unaware of the resident's BP falling below the parameters and when he/she reviewed the MAR, acknowledged the CMA should have held the carvedilol and the amlodipine besylate as the POS directed and as the MAR documented. During staff interview on 4-3-12 at 4:17 P.M. administrative licensed nurse B acknowledged staff did not hold the BP medication as ordered by the physician. The facility lacked a policy and procedure for holding medication for BP medications when indicated. The facility failed to hold 2 BP medications as ordered when his/her BP fell below the	{F 329}		

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{F 329}	Continued From page 45 parameters set by the physician. - Resident #1000's Physician Order Sheet (POS) dated 3/2/12 listed diagnoses that included diabetes mellitus, constipation, joint pain in ankle and shoulder, acute respiratory failure, cardiomyopathy, abnormal posture, urinary tract infection, chronic respiratory failure, morbid obesity, atrial fibrillation, hypothyroidism, hypertension, depressive disorder, anxiety, shortness of breath, backache, deep vein thrombosis of lower extremity, congestive heart failure, acute kidney failure, obstructive sleep apnea, gastroesophageal reflux disease, tracheostomy, hematuria, anemia, chronic airway obstruction, urinary retention, pulmonary embolism/infarct, emphysema, psychosis, mononeuritis, diarrhea, neuropathy and insomnia. The quarterly Minimum Data Set (MDS) 3.0 with an Assessment Reference Date of 3/23/12 recorded the resident had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The MDS further recorded the resident totally dependent on staff for bed mobility, transfers, dressing, toilet use, personal hygiene and required extensive staff assistance for eating, and did not walk or move in his/her wheelchair during the assessment period. The MDS recorded the resident was frequently incontinent of bowel and bladder, not on a toileting program, was at risk for pressure ulcers, had other skin problems, had a pressure reducing device in the bed and chair, and received dressings and ointments. Observation on 3/28/12 at 1:03 P.M. revealed the	{F 329}		

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{F 329}	Continued From page 46 resident lay in his/her bed with a tracheostomy in place. The Medication Administration Record (MAR) dated 3/12 recorded the order dated 1/4/12 for Digoxin 0.125 micrograms (Mcg.) every day for atrial fibrillation. Check apical heart rate and if less than or equal to 60, notify the doctor. The MAR recorded 1 day in March 2012 with the pulse recorded. During an interview on 4/3/12 at 1:08 P.M., licensed staff F stated staff should document the resident's pulse before they gave the Digoxin, and notify the physician if the pulse was 60 or below, and acknowledged staff only recorded the pulse 1 time for the month of March. During an interview on 4/3/12 at 4:17 P.M., administrative nursing staff B stated staff should record the resident's pulses for the Digoxin in the MAR as common sense practice. The facility lacked a policy for pulse monitoring for cardiac medications. The facility failed to adequately monitor the resident's pulse for cardiac medication use.	{F 329}		
{F 353} SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	{F 353}		

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{F 353}	Continued From page 47 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: The facility identified a census of 112 residents with 9 residents sampled. Based on observation, interview and record review, the facility failed to provide sufficient staff/staff supervision to provide services to meet the needs of several residents on 1 unit, identified by deficient practice in multiple care areas. Findings included: - Based on observation, record review and interview, the facility failed to provide adequate pain relief and monitor fluid restriction for resident #1005 and failed to provide education to prevent the development of a wound for resident #1007. Refer to F309. - Based on observation, record review and	{F 353}		

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{F 353}	Continued From page 48 interview,the facility failed to provide assistance for personal hygiene for resident #1000. Refer to F312. - Based on observation, record review and interview, the facility failed to provide adequate perineal care and prevent backflow of urine for resident #1007, and failed to provide adequate perineal care for resident #1002. Refer to F315. - Based on observation, record review and interview, the facility failed to implement and monitor interventions to prevent injury of a fracture for resident #1005. Refer to F323. - Based on observation, record review and interview, the facility failed to monitor the pulse for resident #1000 and failed to monitor the blood pressure for resident #1005. Refer to F329. During an interview on 4/4/12 at 4:44 P.M., administrative nursing staff B stated the facility staff was trained and administration monitored resident care, but the staff did not perform care correctly for perineal care, catheter care, bathing, shaving, skin reporting and medication monitoring for pulses and blood pressures. The facility failed to assure the availability of sufficient qualified nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	{F 353}		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	{F 520}		

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{F 520}	Continued From page 49 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility identified a census of 112 residents. Based on observation, interview and record review, the facility failed to ensure their Quality Assessment and Assurance Committee (QAA) adequately identified deficient areas of practice and developed and implemented appropriate plans of action to correct the deficient practices. Findings included:	{F 520}		

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{F 520}	Continued From page 50 - Based on observation, interview and record review, the facility failed to provide a sanitary environment by keeping resident care equipment clean and properly stored. Refer to F253. - Based on observation, interview and record review, the facility failed to include the resident to participate in planning care and treatment or changes in care and treatment, and failed to review and revise the plans of care. Refer to F280. - Based on observation, interview and record review, the facility failed to follow and execute the dentist's orders for treatment. Refer to F281. - Based on observation, record review and interview, the facility failed to provide adequate pain relief and monitor fluid restriction, and failed to provide education to prevent the development of a wound. Refer to F309. - Based on observation, record review and interview, the facility failed to provide assistance for personal hygiene. Refer to F312. - Based on observation, interview and record review, the facility failed to identify and report a new open skin area on the resident's gluteal fold. Refer to F314. - Based on observation, record review and interview, the facility failed to provide adequate perineal care and prevent backflow of urine. Refer to F315. - Based on observation, record review and interview, the facility failed to implement and	{F 520}		

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{F 520}	Continued From page 51 monitor interventions to prevent injury of a fracture. Refer to F323. - Based on observation, record review and interview, the facility failed to monitor the pulse the blood pressure for residents. Refer to F329. During an interview on 4/4/12 at 4:44 P.M., administrative nursing staff B stated the facility staff was trained and administration monitored the resident care, but the staff did not perform care correctly for perineal care, catheter care, bathing, shaving, skin reporting, fluid restrictions, personal care equipment and medication monitoring for pulses and blood pressures. During an interview on 4/4/12 at 3:26 P.M., administrative staff A stated staff did not identify QAA problems with personal care equipment cleanliness and storage, care plan meeting participation, fluid restrictions, catheter care, monitoring of pulses and blood pressures and following physician or dentist orders, but QAA staff did monitor the performance of incontinence care, falls and care plans. The facility failed to identify, develop and implement appropriate plans of action to have an effective quality assurance program that identified and addressed these issues involving multiple conditions of the residents' care and home.	{F 520}		